DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 0 8

2. STATE: Iowa

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2000
~~February 1, 2000~~

per C Hoverkamp 10/30/00

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.253 & 447.255

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 0
b. FFY 2001 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, pages 1, 2, 2a, and 2b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, page 1 (MS 98-27), page 2 (MS-99-9), and page 2a (MS-96-34)

10. SUBJECT OF AMENDMENT:
Re-basing of the reimbursement rate for skilled nursing facilities

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Jessie K. Rasmussen

13. TYPED NAME:
Jessie K. Rasmussen

14. TITLE:
Director

15. DATE SUBMITTED:
August 9, 2000

16. RETURN TO:
Director
Department of Human Services
Hoover State Office Building, 5th Floor
Des Moines, IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
08/17/00

18. DATE APPROVED:
NOV 2 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 1 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid and State Operations

23. REMARKS:

cc:
Rasmussen
Headlee
CO

SPA CONTROL

Date Submitted 08/09/00
Date Received 08/17/00

FORM HCFA-179 (07-92)

Instructions on Back

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

A. Nursing Facilities That Provide Skilled Care

1. Introduction

Nursing facilities that are certified by Medicare to provide a skilled level of care (formerly called "skilled nursing facilities") receive Medicaid reimbursement based on a prospective per diem rate calculated for each facility. This rate is calculated by applying an annual inflation factor to a base-year per diem rate. The subsections below reflect the details of this reimbursement plan.

2. Definition of Allowable Costs

Determination of allowable costs for the base year is made using Medicare methods in place in December 31, 1998. Cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary, and necessary; and is not in excess of what a prudent and cost-conscious buyer would pay for the given service or item. Only these costs are considered in calculating the Medicaid nursing facility reimbursable cost per diem for purposes of this section.

3. Explanation of Base-Year Per Diem

The base-year per diem rate is the Medicaid cost per diem, as determined using the individual facility's FY 1998 finalized Medicare cost report applied to Medicaid claims data.

If a change of ownership has occurred during FY 1998, and the new owner's cost report covers less than a 12-month period, the provider's FY 1999 finalized Medicare cost report, applied to Medicaid claims data, is used to determine the newly based Medicaid payment rate. Costs of ownership used in determining the new rate are limited to the costs incurred by the previous owner.

For facilities enrolled during or prior to 1998, no other exceptions are granted for use of a base year other than 1998. For facilities that have elected to receive the low Medicare volume prospective payment rate for 1998, the Medicare 1998 prospective payment rate plus ancillary costs attributable to skilled patient days and not payable by Medicare shall be used to determine the facility's Medicaid costs per patient day.

For facilities enrolled since 1998, an "interim" per diem rate is determined. The initial interim rate shall be either:

- The rate used by Medicare or
- For facilities with no rate established by Medicare, a per diem rate based on a projected cost statement from the facility.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

A. Nursing Facilities That Provide Skilled Care (Cont.)

3. Explanation of Base-Year Per Diem (Cont.)

When the facility submits the first cost report to Medicare, the facility shall send a copy to the Medicaid fiscal agent. A new prospective rate is established based on the cost report, effective the first day of the month in which the cost report is received.

The interim and prospective rates may not exceed the established ceiling. Medicare cost reporting principles in effect during the cost reporting period in question will be applied.

4. The Annual Inflation Factor Including Weights and Proxies

During the rebasing process, rates were trended forward by 4.0% to bring the facility rates to the current calendar year.

5. Trending Reimbursement Rates Forward

A facility's calculated rate is its 1999 base year rate, compounded by annual increase factors. A new facility's base rate is established using its first cost report, in accordance with section A.3 of this attachment.

6. Groupings or Classification of Providers

Facilities providing skilled nursing care are classified as either hospital-based or free-standing (not hospital-based) under this reimbursement methodology. A hospital-based facility is a nursing facility under the management and administration of a hospital, regardless of where the beds are physically located.

7. Ceilings, Limits, or Screens

The maximum allowable cost for skilled care is $346.20 per day for hospital-based facilities, and $163.41 for free-standing facilities. This means a facility based on allowable costs shall receive a per diem rate no greater than the maximum rate for the class of facility, unless the facility meets the definition of a disproportionate-share facility and is therefore not subject to the ceiling.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

A. Nursing Facilities That Provide Skilled Care (Cont.)

8. Exceptions to the Rate-Setting Process

Exceptions to the rate-setting process are made under the following circumstances:

a. Disproportionate Share

A disproportionate share of Medicaid recipients occurs when the total cost of services rendered to Medicaid skilled recipients in any one provider fiscal year is greater than or equal to 51% of the total facility's allowable skilled cost for the same fiscal year.

Such a facility shall be paid its computed allowable rate, not to exceed 150% of the present ceiling. The Department determines which providers qualify for this exception. Facilities that meet the disproportionate share exemption before June 1, 1993, are exempt from the ceiling and from the 150% limit.

Nursing facilities enrolled on May 31, 1993, that meet the above disproportionate-share requirements shall continue to be exempted from the payment ceiling if the total cost of services rendered to Medicaid recipients in any one provider fiscal year drops below 51%, but the total cost of services to Medicaid recipients is greater than 35% of the facility skilled nursing allowable cost for the same fiscal year.

For facilities meeting this condition, a 10% reduction in the Medicaid payment rate is made. For each percentage point in the facility's overall utilization rate (rounded to the nearest whole number) below 75%, a further 1% reduction is made in the Medicaid payment rate, in addition to any occupancy adjustment already made by the Medicaid program.

A facility meeting these additional disproportionate-share requirements on or after July 1, 1996, must submit a census report that verifies the Medicaid and overall occupancy of the facility for the entire year immediately before the facility applies for reimbursement under disproportionate-share provisions. Also, the facility's initial rate must be the allowable Medicaid rate on the effective date less 10% and any further applicable percentage reductions.

Subsequent rate calculation is based on the annual cost report prepared by the facility, subject to the limits described in this section and subject to an allowable rate of increase as described under Section A.4.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

A. Nursing Facilities That Provide Skilled Care (Cont.)

8. Exceptions to the Rate-Setting Process (Cont.)

b. Ventilator Incentive

A special incentive to care for ventilator-dependent persons is added to a facility's rate if the following conditions are met:

- The patient meets requirement for skilled and ventilator care.
- The facility rate does not exceed $50 per day over the ceiling.

The incentive is up to $50 per day. A facility with a rate over the ceiling but less than $50 per day over the ceiling shall receive an amount to bring the facility up to the ceiling plus $50.

For a person successfully weaned off the respirator, the incentive payment shall continue for 30 days.